DATA SUBCOMMITTEE REPORT TO
HOSPITAL ADVISORY GROUP

February 13, 2006

The Data Subcommittee met on Thursday, February 2 from 1:00 – 3:30 at GHA. The primary purpose was to review preliminary results of the ICTF survey recently completed by the hospitals.

Members present were:

Glenn Pearson – GHA (chair)
Steve Holleman – Shepherd Center
Robert McVicker – Medical College of Georgia
Rhonda Perry – Central Georgia Health System
Andy Smith – Flint River Hospital
Charlotte Vestal – Crisp Regional Hospital

A number of DCH staff attended (including Carie Summers and Jim Connelly) as well as nearly two dozen other hospital representatives.

The Myers and Stauffer consultants indicated that the data that will be used to calculate ICTF payments come from different sources and have different degrees of reliability. The most reliable should be the paid claims data, followed by the as-filed cost reports, and finally the self-reported survey data.

Myers and Stauffer consultants indicated that they are scrutinizing the ICTF survey data with the most rigor and suggested a number of check figures that can be run on the survey results to assess data accuracy. Although they are reviewing all the data for reasonableness, the areas that will receive the greatest scrutiny are the out-of-state data and the uninsured patient data. The specific metrics suggested were:

- Payments Made/Gross Charges %
- Gross Charges/Eligible Day
- I/P and O/P Uninsured Charges/Total Charges %
- Uninsured Payments/Uninsured Charges

The committee recommended adding the following tests:

- Total Uninsured Charges
- Total Out-of State Charges

Myers and Staffer will sort the database on each of the above variables and will look for outlier hospitals whose results appear to be significantly higher or lower than those of other hospitals. They will look for natural breakpoints in the results and material

differences. There may be good reasons why some hospitals' results vary, but this analysis will help the consultants focus on the areas most likely to need correction. If DCH staff feel results for a given hospital appear unreasonable, it may elect to do further data audits.

The committee agreed that the above are good measures and the screening methodology is sound.

The issue of which cost-to-charge ratio (CCR) to use was raised by a committee member. The primary advantage of the facility-wide CCR is that it is more stable and easier to audit than the Medicaid CCR. On the other hand, the Medicaid CCR probably more accurately reflects the activity of low-income patients. Jim Connolly from DCH reported that although in prior years, the overall CCR may have yielded more total federal matching dollars, this does not appear to be the case now. Either method would seem to maximize the match.

Following additional discussion, a committee member made the motion that the Data Subcommittee revise its prior decision and recommend that Hospital Advisory Committee use the Medicaid CCR in its ICTF calculations. After an appropriate second, and additional discussion, the committee voted 4-1 to support the motion.

DCH staff reported that Friday, February 10 would be the deadline for making changes in self-reported data and that initial ideas of data modeling would be presented at the February 13 Hospital Advisory Committee.

There being no further business, the group adjourned at 3:30 p.m.